NOTICE: THIS APPLICATION MUST BE PRINTED ON 14 INCH PAPER

INTERMITTENT EMPLOYEES GROUP — NEW JERSEY STATE HEALTH BENEFITS PROGRAM APPLICATION

HA-0803-0108p

Division of Pensions and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

1. EMPLOYEE INFORMATION — This section must be filled out *completely*. Please print or type.

Social Security Number ___ — ___ — ____

Last Name _____ Title (Jr.,Sr., etc.) ___

First Name _____ MI ___

Street Address (Include Apartment #) _____

City _____ State ___

Zip Code + 4 _____ — ____ Date of Birth (mm/dd/yy) ____ Gender (M/F) ___

Status: ☐ - Single ☐ - Married ☐ - Civil Union ☐ - Domestic Partnership ☐ - Divorced ☐ - Widowed

(Area Code) Home Telephone Number ___ — ___ — ____

2. MEDICAL COVERAGE

2a. EMPLOYEE SELECTION

☐ I wish to be covered under NJ DIRECT15 **and** the Employee Prescription Drug Plan.

☐ I wish to be covered under NJ DIRECT15 **only** and *waive* Employee Prescription Drug Plan coverage.

☐ I wish to be covered under the Employee Prescription Drug Plan **only** — and waive NJ DIRECT15 coverage.

2b. LEVEL OF NJ DIRECT15 COVERAGE

☐ - Single ☐ - Member & Spouse/Civil Union Partner ☐ - Family
☐ - Member & Domestic Partner – (see instructions) ☐ - Parent & Child(ren)

2c. LEVEL OF EMPLOYEE PRESCRIPTION DRUG COVERAGE

☐ - Single ☐ - Member & Spouse/Civil Union Partner ☐ - Family
☐ - Member & Domestic Partner – (see instructions) ☐ - Parent & Child(ren)

3. WAIVER OF COVERAGE

☐ I elect to **waive both** medical and prescription drug coverage for myself and for my dependents (see instructions).

4. DEPENDENT INFORMATION — *List all eligible dependents (see reverse).*

	Last Name	First Name	MI	Date of Birth Month Day Year	Gender (M/F)	Social Security Number	Natural (C) Adopted (A) Step (S) Foster (F) Legal Ward (L) (See Instructions)
☐ **Spouse/Partner -**							
Children							

5. TYPE OF ACTIVITY (complete only if requesting changes to existing coverage)

5a. ADDITION OF DEPENDENT

☐ Marriage - Date of Event (Mo/Day/Yr) _____
(Copy of Marriage Certificate required)
Former Name _____

☐ Civil Union/Domestic Partner - Date of Event (Mo/Day/Yr) _____
(Copy of Civil Union or Domestic Partnership Certificate required)

☐ Birth of Child ☐ Adoption/Guardianship — Proof Required
Date of Event (Mo/Day/Yr) _____

5b. DELETION OF SPOUSE OR PARTNER

☐ Separation ☐ Divorce ☐ Dissolution of Civil Union
☐ Termination of Domestic Partnership ☐ Death of Spouse/Partner
Date of Event (Mo/Day/Yr) _____

5c. DELETION OF CHILD

☐ Deletion of Child - Date of Event (Mo/Day/Yr) _____
Child's Name _____
Child's SSN _____
Give Reason _____

5d. OTHER CHANGES

☐ Change in last name only
(List Former Name) _____

☐ Change in Soc. Sec. # *(Attach copy of Social Security card)*
(List Former Soc. Sec. #) _____

☐ Change in Birth Date *(Attach copy of birth certificate)*
(List Name and Correct Date) _____

☐ Other - give reason (*i.e.*, address change, dependent returns from military service)

DIVISION USE ONLY

Effective Dates: ____ ____ ____ ____ ____ ____

Event Reason: ___

EMPLOYER CERTIFICATION

To Be Completed By Employer

Employer Name: _____

Location # 0 0 0 1 0 0

STATE ONLY: Payroll # ___ Union Code (Rx) Only ___

MEMBER ACTION (Must be completed):

☐ **New Enrollment**

EMPLOYER CERTIFICATION — I certify that this intermittent employee has satisfied at least 750 regular pay status hours by the end of Fiscal Year, 20_____ and is, therefore, eligible for enrollment under the provisions of the State Health Benefits Program, and that the information supplied on this form is true to the best of my knowledge.

_____
Signature of Certifying Officer

_____
Telephone # Date Mailed

6. Employee Certification — I certify that all the information supplied on this form is true to the best of my knowledge. I understand that if I waive my right to coverage at this time, enrollment is not normally permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I also understand that there is no guarantee of continuous in-network participation by medical service providers, either doctors or facilities in the NJ DIRECT15 plan. If either my physician or medical center terminates participation in NJ DIRECT15, I must select another doctor or medical center participating in NJ DIRECT15 to receive the in-network benefit. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the assignee may require.

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

_____ _____
Employee's Signature Date Completed

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COMPLETING THE INTERMITTENT EMPLOYEES GROUP NJ STATE HEALTH BENEFITS PROGRAM APPLICATION

QUICK REFERENCE

- This application is for use by intermittent State employees who are eligible for State Health Benefits Program coverage. For more information about this coverage and the eligibility requirements for intermittent employees, see Fact Sheet #69, *SHBP Coverage for State Intermittent Employees.*
- To **enroll** for the first time complete all sections of the application with the exception of section 5.
- To **change coverage level** (adding/deleting dependents) complete sections: 1, 2a, 2b, and 2c (if applicable), 4, (be sure to list **all** eligible dependents), 5 (listing why you are changing coverage level), and 6.
- To **add a dependent** complete sections: 1, 2a, and (as applicable) 2b and/or 2c, 4 (list all eligible dependents), 5a, and 6.
- To **terminate/decline coverage** complete sections: 1, and either 2a and 2b to terminate/decline prescription drug coverage only, **or** 2a and 2c to terminate/decline NJ DIRECT15 coverage only, **or** 3 to waive **all** coverage, and 6. Note: If you are declining enrollment for yourself or any or all of your eligible dependents because of other group health insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP medical plan, provided that you request enrollment within 60 days after your other group health coverage ends.

SECTION 1 — EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

SECTION 2 — MEDICAL COVERAGE

2a. **Check only one box** indicating if you want NJ DIRECT15 **and** Employee Prescription Drug Plan coverage, NJ DIRECT15 coverage **only,** or Employee Prescription Drug Plan coverage **only**.

2b. If you are selecting NJ DIRECT15 coverage, check the NJ DIRECT15 coverage level desired.

2c. If you are selecting prescription drug coverage, check the Employee Prescription Drug Plan coverage level desired.

SPOUSE: This is a person of the opposite sex to whom you are legally married. A photocopy of the *Marriage Certificate* is required for enrollment.

CIVIL UNION PARTNER: This is a person of the same sex with whom you have entered into a civil union. A photocopy of the New Jersey *Civil Union Certificate* or a valid certification from another jurisdiction that recognizes same-sex civil unions is required for enrollment. The cost of a civil union partner's coverage may be subject to federal tax (see your employer or Fact Sheet #75, *Civil Unions,* for details).

DOMESTIC PARTNER: This is a same-sex domestic partner, as defined under Chapter 246, P.L. 2003, the Domestic Partnership Act, of any State employee, State retiree, or an eligible employee or retiree of a SHBP participating local public entity if the local governing body adopts a resolution to provide Chapter 246 health benefits. A photocopy of the New Jersey *Certificate of Domestic Partnership* dated prior to February 19, 2007 or a valid certification from another jurisdiction that recognizes same-sex domestic partners is required for enrollment. The cost of same-sex domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act,* for details).

SECTION 3 — WAIVER OF COVERAGE

If you do **not want to be covered** under any health or prescription drug plan, check this box. Note: Once you decline or cancel coverage, enrollment is not normally permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).

SECTION 4 — DEPENDENT INFORMATION

Only eligible dependents may be listed. Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b and 2c. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. You may cover an eligible spouse, civil union partner, or eligible same-sex domestic partner (as defined in Section 2, above). If you have listed a child that is a foster child, stepchild, legal ward, has a different last name than the employee, or you are electing Parent and Child coverage, proof of dependency is required (contact your payroll/personnel representative for an SHBP *Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 4, and 6.

Note: If you are deleting dependents, do not list them in this section. Refer to section 5b and 5c.

SECTION 5 — TYPE OF ACTIVITY

5a. If you are adding a dependent, check the appropriate box and the event date.

5b. If you are deleting a dependent spouse/partner, check reason and indicate the event date.

5c. If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.

5d. For other changes, check the appropriate box and give reason.

SECTION 6 — EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

Misrepresentation: Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

EMPLOYER CERTIFICATION

Must be completed by your employer. This application must be certified by the employer before submitting it to the SHBP. The Certifying Officer should:

1) Verify the employee's eligibility;

2) Verify that the application is legible and completed in its entirety;

3) Verify that the employee's selected plans and coverage levels are appropriate; and

4) Complete the Employer Certification section in its entirety.